



SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

Dear Provider:

Thank you for your recent request for the *Medi-Cal Supplemental Changes* (DHS 6209, revised 7/04) form. Please complete the enclosed form and return it to:

California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

PLEASE NOTE: Effective January 1, 2004, new law governing enrollment of providers in the Medi-Cal program required providers to complete a new application package for a change of business address.

Please read all the instructions included in the *Medi-Cal Supplemental Changes* form carefully and complete each item requested. Incomplete forms will be returned. For enrollment forms, information about the completion of enrollment forms and the regulatory requirements for participation in the Medi-Cal Program, please visit the Medi-Cal Web site at www.medi-cal.ca.gov and click the "Provider Enrollment" link.

It is your responsibility to report to the Department of Health Services any modifications to information previously submitted within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHS 6209, revised 7/04) form. However, if you are reporting a change of ownership of 50 percent or more, or a change of business address, you must complete a new application package.

If you have any questions, please submit your inquiry in writing to the above address.

Provider Enrollment Branch
Payment Systems Division

(Revised 10/04)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL SUPPLEMENTAL CHANGES

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is a means to inform the California Department of Health Services of changes to previously submitted provider information and documentation. Applicants or providers may be subject to an on-site inspection prior to enrollment.

Omission of any required information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations, Section 51000.50.

Enter the legal provider name as listed with the Internal Revenue Service (IRS).

Enter your Medi-Cal provider number in the space provided.

Enter the date you are completing the application.

Provider type: Enter your provider type in one of the boxes provided.

Action requested: Check (✓) the applicable action you would like made to the provider master file.

Please complete only those boxes necessary to provide the information you are adding, changing, or deleting or to complete the action requested. Be sure to complete boxes 29–34; complete number 35, if applicable.

General Information

1. “Business name”—the name of the applicant or provider if different from legal name. If this is a fictitious business name, provide a copy of the Fictitious Business Name Statement or Fictitious Name Permit number and effective date.
2. “Business telephone number”—the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine shall not be used as the primary business telephone.
3. “Pay-to address”—the address at which the applicant or provider wishes to receive payment. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
4. “Mailing address”—the address where the applicant or provider wishes to receive general Medi-Cal correspondence including Provider Bulletins and Provider Manual updates.
5. a. Insert the Clinical Laboratory Improvement Amendment (CLIA) certificate number. Attach a legible copy of the CLIA Certificate.
b. Insert the State Laboratory License/Registration number. Attach a legible copy to the application.
6. Insert the Medicare billing number.
7. Insert the Seller’s Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller’s Permit.
8. Insert any local business license, certificate, or permit numbers for any city or county or city and county where you conduct your business activities and attach legible copies to the application.
9. Insert the specialty code(s) to be added or deleted.
10. For a change of ownership or control interests of less than 50 percent, list the new ownership information in this space and submit a new Medi-Cal Disclosure Statement (DHS 6207) for all new ownership interests. If there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Section 51000.15, since the information provided in the last complete application that was approved for enrollment, a complete application package must be submitted pursuant to Title 22, California Code of Regulations, Section 51000.30(b).
11. List the name(s) and applicable information of the provider(s) being deleted.
12. “Hours of operation”—the business days and hours the provider is available for service to Medi-Cal beneficiaries.
13. Check the appropriate boxes and complete all requested information.
14. Enter the change in the business activity you are adding and the licensing information, if applicable. Attach legible copies of any licenses, certificates, or permits required. If you have questions regarding the Bureau of Home Furnishings license, please call the Bureau at (916) 574-0280; or for the Home Medical Device Retailers license call the Food and

Drug Branch at (916) 650-6518. To calculate percentages of business activities, refer to DHS 6201, Medi-Cal Durable Medical Equipment Provider Application. If deleting incontinence medical supplies, check the box.

15. "Geographic Area(s) Served"—those areas in which the provider will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit with the application. If the city/county does not require a license/permit, you must attach a letter from that city/county with the application which states the city/county does not require a license/permit. It is the applicant's or provider's responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.
 16. Enter full legal name of driver or pilot. Enter the driver's license number on the California Driver's License issued by the California Department of Motor Vehicles or the pilot's license number issued by the Federal Aviation Administration for the individual listed. Attach a legible copy of the license for each driver or pilot with the application. Enter all additional requested information. Attach a legible copy of the DL-51 to the application.
 17. Insert the first, middle, and last name of the pharmacist-in-charge at the business location.
 18. Provide the social security number of the pharmacist-in-charge. (Optional—See Privacy Statement on page 8.)
 19. Insert the license number of the pharmacist-in-charge.
 20. Provide the driver's license or state-issued identification number and state of issuance of the pharmacist-in-charge. Attach a legible copy of the driver's license or state-issued identification card to this application.
 - 21–26. Answer all questions as they pertain to the pharmacist-in-charge. If any answers are checked yes, list all details to include license number, dates, licensing agency, Medi-Cal provider information and numbers, etc., in number 27.
 27. Provide all details to any yes answers for numbers 21–26.
 28. Check the appropriate boxes and complete all requested information in this question.
 29. Printed name of provider signing this form—the first, middle, and last name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to the Department for enrollment or continued enrollment as a provider in the Medi-Cal program.
 30. Enter the date of birth of the individual named in number 29.
 31. Check (✓) the gender of the individual named in number 29.
 32. Provide the driver's license or state-issued identification number and state of issuance of the individual listed in number 29. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
 33. Provide the social security number of the individual named in number 29. Provision of the social security number is optional (see Privacy Statement on page 8).
 34. An original signature of the individual listed in number 29 is required. Also provide the title of the person signing the application who is the sole proprietor, partner, corporate officer, or by an official representative of a governmental entity or nonprofit organization who has the authority to legally bind the applicant or provider. Include the city, state, and the date where and when the application was signed.
 35. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.
- ✓ Remember to attach a legible copy of the following, if applicable:
- ☐ Fictitious Business Name Statement or Fictitious Name Permit
 - ☐ TIN verification
 - ☐ CLIA Certificate
 - ☐ State Laboratory License/Registration
 - ☐ Seller's Permit
 - ☐ Professional license, permit, or certificate
 - ☐ Business license, permit, or certificate

- ☐ Licenses associated with business activities:
 - ☐ Bureau of Home Furnishings License
- ☐ Furniture and Bedding License
- ☐ Furniture License
- ☐ Bedding License
 - ☐ Medical Device Retailer Certificate
 - ☐ Medical Device Retailer Exemptee Certificate
 - ☐ Other licenses, certificates, permits, etc.
- ☐ Pharmacist-in-Charge License
- ☐ Pharmacist-in-Charge driver's license or identification card
- ☐ FAA certificate
- ☐ FAA pilot's license for each new pilot
- ☐ Certificates for first aid and CPR for each new driver
- ☐ Driver's license for each new driver
- ☐ DMV DL-51 form signed by a physician for each new driver
- ☐ Standard pre-employment drug and alcohol tests lab results for each new driver
- ☐ DMV driving history printout for each new driver
- ☐ Driver's license or identification card of person signing application
- ☐ Signed Medi-Cal Disclosure Statement (DHS 6207)



MEDI-CAL SUPPLEMENTAL CHANGES

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 323-1945

FOR STATE USE ONLY

Legal provider name (as listed with the IRS)	Medi-Cal provider number	Date
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PROVIDER TYPE (check one)

- | | |
|--|--|
| <input type="checkbox"/> DME | <input type="checkbox"/> Physician |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Provider group |
| <input type="checkbox"/> Orthotic and prosthetic | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Other provider type (please describe) _____ |

ACTION REQUESTED (check all that apply)

Add:

- ☐ Business activity
- ☐ Clinical Laboratory Improvement Amendment (CLIA)
- ☐ Doing-Business-As (DBA) name
- ☐ Licenses, permits, certificates, etc.
- ☐ Medical transportation driver or pilot
- ☐ Seller's Permit
- ☐ Medicare billing number
- ☐ Specialty code

Delete:

- ☐ Clinical Laboratory Improvement Amendment (CLIA)
- ☐ Rendering provider—specify group provider number(s): _____
- ☐ Medical transportation vehicle, driver, or pilot
- ☐ Specialty code

Change:

- ☐ Address and/or phone (pay-to or mailing only)
- ☐ Medical transportation driver or pilot
- ☐ Ownership or control interest less than 50 percent
- ☐ Pharmacist-in-charge
- ☐ Managing employee
- ☐ Hours of operation

Miscellaneous:

- ☐ Deactivate provider number
- ☐ PIN (Provider Identification Number)
 - ☐ Issuance (new PIN)
 - ☐ Confirmation (existing PIN)

Complete only the boxes specific to the action requested. Complete boxes 29–34. Complete box 35, if applicable.

General Information

1. Business name, if different		2. Business telephone number ()	
Is this a fictitious business name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date	
(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement or Fictitious Name Permit, if applicable.)			
3. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
4. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code
5.a. Clinical Laboratory Improvement Amendment (CLIA) certificate number (attach a legible copy)	5.b. State Laboratory License/Registration number (attach a legible copy)	6. Medicare billing number (attach a legible copy)	
7. Seller's Permit number (attach a legible copy)	8. Any local business license, permit or certificate numbers (attach a legible copy)	9. Specialty code(s) Add: _____ Delete: _____	

10. Change of Ownership or Control Interests—Not to exceed 49% cumulative changes since last complete application approved for this provider number.

Type of entity (check one)

☐ Sole proprietor

☐ Partnership

☐ Corporation

☐ Nonprofit

☐ Limited liability company

☐ Government

☐ Other (describe) _____

Are you adding owners, managing employees, or change in interest? If so, please provide the following information:

Name	Title	Ownership percentage
Name	Title	Ownership percentage
Name	Title	Ownership percentage
Name	Title	Ownership percentage
Name	Title	Ownership percentage

Are you deleting owners? If so, please provide the following information:

Name	Title	Ownership percentage
Name	Title	Ownership percentage
Name	Title	Ownership percentage
Name	Title	Ownership percentage
Name	Title	Ownership percentage

11. Rendering provider to be deleted from the group (attach additional sheets as necessary)

Name	Provider number	Medicare number	Effective date of deletion
Name	Provider number	Medicare number	Effective date of deletion
Name	Provider number	Medicare number	Effective date of deletion
Name	Provider number	Medicare number	Effective date of deletion
Name	Provider number	Medicare number	Effective date of deletion

12. Change in hours of operation

The business days and hours of operation are:

Days: _____ Hours: _____

FOR DURABLE MEDICAL EQUIPMENT PROVIDERS ONLY

13. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies, and/or medical supply items?

☐ Yes ☐ No

Are your equipment and/or supplies:

☐ A. In stock on the premises, or

☐ B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation: Days: _____ Hours: _____

If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code
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Who holds an ownership interest in the warehouse? (Use additional sheets if necessary.)

Name		Telephone number ()	
Address (number, street)	City	State	ZIP code

14. Change in Business Activities

Add (please describe activities and percentages to equal 100%. Attach additional page.) _____

If you are adding a business activity which requires any type of license, certificate, permit, etc., please list the information here and attach a legible copy of the license to this application:

Bureau of Home Furnishings license (see instructions):

Furniture and Bedding or Furniture Retailer License number (attach a legible copy): _____ Registry number: _____

(If you are a DME provider and are renting beds, your license must bear a Registry number.)

Issuance date: _____ Expiration date: _____

Medical Device Retailer license number (attach a legible copy): _____

Issuance date: _____ Expiration date: _____

Medical Device Retailer Exemptee license number (attach a legible copy): _____

Issuance date: _____ Expiration date: _____

Other license, certificate, permit, etc.: _____

☐ Delete incontinence medical supplies

FOR TRANSPORTATION PROVIDERS ONLY

15. Geographic area(s) served (list city/county—attach copy of permit)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

16. Driver Information (attach a legible copy(ies) of driver's license(s) and DMV DL-51(s)) (see instructions)

Driver's Name(s)	Driver's License Number	Year of Expiration	DMV DL-51 (Driver's Only)	
			Effective Date	Expiration Date

Pilot information (attach a legible copy(ies) of pilot's license(s))

Pilot's Name(s)	Pilot's License Number	Year of Expiration

Ensure legible copies of the following documents are attached to the application (as applicable):

- ☐ DMV DL-51 form signed by a physician for each driver
- ☐ FAA pilot's license for each pilot
- ☐ California driver's license for each driver
- ☐ Certificates for first aid and CPR for each driver
- ☐ Standard pre-employment drug and alcohol tests lab results for each driver
- ☐ DMV driving history printout for each driver

FOR PHARMACIES ONLY**NEW PHARMACIST-IN-CHARGE (PIC)**

17. Printed name (last)			(first)	(middle)
18. PIC social security number (Optional —Privacy Statement on page 8.)		19. PIC license number (attach a legible copy of license and renewal, if applicable)		
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		
20. Driver's license or state-issued identification card number (attach a copy)		State of issuance		
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If you answer yes to questions 21–26, give details in number 27 (see instructions)

	Yes	No
21. Has the PIC's individual license, certificate, or other approval to provide health care ever been suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
22. Has the PIC's individual license, certificate, or other approval to provide health care ever been lost or surrendered?	<input type="checkbox"/>	<input type="checkbox"/>
23. Does the PIC have an ownership or control interest in any other medical or Medi-Cal health care provider?	<input type="checkbox"/>	<input type="checkbox"/>
24. Has the PIC previously participated in the Medi-Cal program?	<input type="checkbox"/>	<input type="checkbox"/>
25. Has the PIC ever participated in another state's Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>
26. Has the PIC ever been suspended from a Medicare or Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>
27. Details for questions 21–26 (see instructions)		
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28. Do you have a retail business open and available to the general public which meets all local laws and ordinances regarding business licensing and operations and is readily identifiable as a place in which the applicant or provider engages in sales of items? ☐ Yes ☐ No

If no, please explain:

Are your equipment and/or supplies:

- ☐ A. In stock on the premises, or
- ☐ B. In a warehouse under the applicant's or provider's direct control.

Business days and hours of operation: Days: Hours:

If B is checked, provide the following information for the warehouse:

Address (number, street)	City	State	ZIP code
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>

Who holds an ownership interest in the warehouse? (Attach additional sheets if necessary.)

Name		Telephone number	
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	
Address (number, street)		City	State
<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div>

Information About Provider

29. Printed name (last) (first) (middle)			30. Date of birth	31. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
32. Driver's license or state-issued identification number and state of issuance (attach a legible copy)		33. Social security number (Optional —see Privacy Statement below.) ____ - ____ - ____		

34. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of provider

Title

Executed at: _____, _____ on _____
(City) (State) (Date)

35. Notary Public—Please see number 35 in the instructions for who must notarize.

Privacy Statement
(Civil Code Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, (916) 323-1945.